Appendix D Prior Authorization Information (Home Health)

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INTRODUCTION

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the

provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the recipient was eligible under fee-for-service (not MCO enrolled) for dates where the recipient has subsequently become enrolled with a DMAS contracted MCO.

Srv Auth decisions by the DMAS Srv Auth contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify recipient eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled recipients, the provider must follow the MCO's Srv Auth policy and billing guidelines.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM (Home Health)

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor’s authorization for a period of not less than 90 calendar days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and back to Medicaid Fee-For Service (FFS) Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the Srv Auth contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
C. For CCC Plus Waiver Services, Cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Srv Auth Contractor's service authorization but the member's CCC Plus eligibility has been retrovoided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The Srv Auth contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link:

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Communication

Provider manuals are located on the DMAS web portal and KEPRO websites. The

contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.comand clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found under Service Authorization Checklists on KEPRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Outpatient* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

Submitting Requests For Services (Home Health)

The contracted entity that provides service authorization services to DMAS is Keystone Peer Review Organization (KEPRO). Contact information for KEPRO is as follows:

KEPRO

2810 N. Parham Road, Suite 305

Henrico, VA 23294

Phone: (804) 662-8900 (Richmond)

1-888-827-2884 (Toll Free)

1-888-VAPAUTH

Fax: 1-877-652-9329

1-877-OKBYFAX

The purpose of service authorization is to validate that the service being requested is

medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service; payment is contingent upon

passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Service authorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer.

Service Authorization for Home Health Services

Face-to-Face Encounters for Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for initiation of home health services (as defined in 12VAC30-50-160) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) within 90 days prior to when the individual enrolled in Medicaid begins the services or within 30 days after the individual begins the services. The Medicaid face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires home health services.

The face-to-face encounter must be conducted by one of the following five (5) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist acting within the scope of their practice as defined by state law;A certified nurse midwife;
- A licensed physician assistant working under the supervision of the physician who orders the individual's services; or
- For individuals admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician. For the home health services that exceed five (5) visits and require service authorization, home health providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met.

Additional details may be found in Chapters IV and VI of the Home Health Provider Manual.

Service Limitations

Skilled nursing, physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per participant and per discipline annually without service authorization. Initial skilled nursing and therapy evaluations are included in the five (5) visits. Visits include those services provided by home health agencies and/or rehabilitation agencies. Limits are specific per discipline and participant, regardless of the number of providers rendering services. "Annually" is defined as July 1st through June

30th.

The provider must maintain documentation to justify the need for services. Srv Auth is required before payment will be made for any visits over 5 annually.

Evaluations must be related to the admission or readmission to service or to a significant change in the condition of the participant. For continued authorization beyond the initial period providers must submit a request prior to the Srv Auth end date. Reimbursement shall not be made for additional services without Srv Auth. Care rendered beyond the 5th visit allowed annually which has not been authorized shall not be approved for reimbursement.

Srv Auth must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims. Srv Auth is required when more than 5 visits are medically necessary per fiscal year as noted above. When a participant has Medicare Part B coverage, Srv Auth is not required. If Medicare denies the claim and/or if Medicare benefits are exhausted, the provider may request authorization as a retrospective review. Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must request a retrospective service authorization.

Providers may obtain information regarding service limit utilization by contacting any of the following:

DMAS Provider HelpLine 1-800-552-8627 (in-state long distance)

1-804-786-6273 (local and out-of-state customers)

MediCall System 1-800-772-9996

1-800-884-9730

1-804-965-9732 (Richmond area)

Automated Response System (ARS): www.virginiamedicaid.dmas.virginia.gov

Service Authorization Processing

Srv Auth for skilled nursing and rehabilitation services must be obtained through KEPRO. All Srv Auth requests, as well as any information submitted in response to pend letters, must be directed to KEPRO. If the provider fails to submit information prior to the completion of the 5th visit, retroactive authorization will not be granted. Authorization will begin with the date the request is received at KEPRO. Any service provided without Srv Auth in excess of the 5th visit limitation will not be reimbursed.

To request service authorization, contact KEPRO, the DMAS Srv Auth contractor. For information regarding the service authorization submission process, refer to the

“Submitting Requests for Service Authorizations” section in this Appendix D.

The following information is required in order to determine if the individual meets criteria: (1) a physician order and nursing plan of treatment or therapy evaluation; (2) verification of medical necessity for the service; and (3) evidence of discharge planning.

Service authorizations are specific to the recipient, provider, service code, and specific dates of service. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer. If a claim for a service requiring service authorization does not match the authorization, the claim will be pended for review or denied.

DMAS requires the following for Home Health Services:

- The participant meets InterQual criteria upon initial and/or recertification review. These criteria may be obtained through:

McKesson Health Solutions LLC

275 Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: mckesson.com or InterQual.com

Recertification Review

Prior to the last Srv Auth end date, or the next visit, the provider must submit a request for continued Srv Auth. This request will be reviewed to determine if DMAS criteria and documentation requirements are met. A decision will be made to approve, pend, deny, or reject the request. Approvals will include a specific number of units and dates of service.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION (Home Health)

DMAS' Service Authorization Contractor, KEPRO, is moving to their own Provider Portal

"Atrezzo Connect" effective October 31, 2011 at 6:00 a.m. The previous system (iEXCHANGE™) will not be available to providers, effective 5:00 p.m., October 28, 2011. For direct data entry requests, providers must begin using the new Atrezzo Connect Provider Portal. The new Atrezzo Connect Provider Portal advantages include easier system changes when DMAS program changes occur and specific prompts and edits related to certain programs in the new system. DMAS-related information from the previous system will be transferred into KEPRO's new Atrezzo Connect Provider Portal prior to October 31, 2011.

The registration process for providers is much simpler and quicker than with

iEXCHANGE™ and happens immediately on-line. Existing iEXCHANGE™ users can log onto Atrezzo Connect without re-registering, using a special username consisting of their iExchange group ID, a hyphen, and their iExchange username. The initial password is also the iExchange group ID. They will then be given a one-time opportunity to change their username and password. Users from providers not currently registered with iExchange will select a username and password and then establish their legitimate connection to the selected NPI# by providing information taken from the most recent remittance advice. After logging in, Group administrators and Administrators within Atrezzo can specify other users within their organization and establish preferences for servicing providers, diagnoses and procedure codes. The Atrezzo Connect User Guide is available at dmas.kepro.com: Click on the Training tab, then the General tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO will also accept requests by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the service authorization requirements and methods of submission may be found on the contractor's website at https://dmas.kepro.com.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file, and are subject to review during Quality Management Review (QMR).

Direct all telephone inquiries regarding Service Authorization to the DMAS Provider Helpline at the telephone numbers listed in Chapter I of this manual.

KEPRO does not review requests when participants have Medicare Part B.

Except when Medicare is the primary payer, when more than five visits are medically necessary, the provider must request service authorization. When a recipient has Medicare Part B coverage, service authorization is not required. If Medicare denies the claim, the provider may request authorization as a retrospective review. This is the only time that a retrospective review is allowed, and it must be done within 30 days of the notification of the Medicare denial.

Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of

Medicaid eligibility.

OUT-OF-STATE PROVIDER INFORMATION

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural*

Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO".

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days, KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the

Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

"Effective September 12, 2016, KEPRO added additional questions to the out-of-state provider questionnaire (found on the Provider Portal):

a. Question #2 - If the medical services are needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel."
b. Question #5 - "In what state is the provider rendering the service and/or delivering the item physically located?"
c. Question #6 - "In what state will this service be performed?"
d. Question #7 - "Can this service be provided by a provider in the state of

   Virginia? If a provider answers "No", then additional question #7.2.1 asks: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10120 and 42 CFR 431.52.

Early Periodic Screening Diagnosis and Treatment Service Authorization

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

1. EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member.

2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

Example of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the

wheelchair does ameliorate his medical condition and allows him to be transported safely.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

NOTE: Effective November 1, 2012, EPSDT specialized services that are service authorized by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor include:

Hearing Aids and Related Devices
Assistive Technology

Private Duty Nursing

Personal Care and Attendant Care Services

Requests for EPSDT services **not contracted to be reviewed and authorized by KEPRO**

may be sent to:

DMAS Medical Support Unit

Fax: 804-452-5450 Phone: 804-786-8056

Medicaid Expansion

On January 1, 2019 Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace. The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health
DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and

Community Based Service
Preventive and wellness
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.